BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Amended Accusation Against:	)	
WILLIAM ARTHUR LANDES, M.D.	)	**Case No. 800-2014-009768**
Physician's and Surgeon's Certificate No. G68279	)	
Respondent	)	

DECISION

The attached Stipulated Surrender of License and Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on April 15, 2019

IT IS SO ORDERED April 8, 2019 .

MEDICAL BOARD OF CALIFORNIA

By: Kimberly Kirchmeyer
Executive Director

XAVIER BECERRA
Attorney General of California
MARY CAIN-SIMON
Supervising Deputy Attorney General
State Bar No. 113083
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 510-3884
Facsimile: (415) 703-5480
Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Amended Accusation Against: **WILLIAM ARTHUR LANDES, M.D.** **Physician's and Surgeon's Certificate No. No. G 68279** Respondent.	Case No. 800-2014-009768 OAH No. 2018030766 **STIPULATED SURRENDER OF LICENSE AND ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Mara Faust, Deputy Attorney General.

2. William Arthur Landes, M.D. (Respondent) is represented in this proceeding by attorneys Thomas J. Doyle, and Chad Couchot whose address is: 400 University Avenue, Sacramento, CA 95825-6502.

3. On or about April 2, 1990, the Board issued Physician's and Surgeon's Certificate No. No. G 68279 to William Arthur Landes, M.D. (Respondent). The Physician's and Surgeon's

Certificate No. was in full force and effect at all times relevant to the charges brought in Amended Accusation No. 800-2014-009768 and will expire on January 31, 2020, unless renewed.

JURISDICTION

4. Amended Accusation No. 800-2014-009768 was filed before the (Board), and is currently pending against Respondent. The Amended Accusation and all other statutorily required documents were properly served on Respondent on January 23, 2018. Respondent timely filed his Notice of Defense contesting the Amended Accusation. A copy of Amended Accusation No. 800-2014-009768 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Amended Accusation No. 800-2014-009768. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Amended Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent understands that the charges and allegations in Amended Accusation No. 800-2014-009768, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate No. G 68279.

9. For the purpose of resolving the Amended Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could

establish a factual basis for the charges in the Amended Accusation and that those charges constitute cause for discipline. Respondent hereby gives up his right to contest that cause for discipline exists based on those charges.

10. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Physician's and Surgeon's Certificate No. G 68279 without further process.

11. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked license in effect at the time the petition is filed, and all of the charges and allegations contained in Amended Accusation No. 800-2014-009768 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

CONTINGENCY

12. Business and Professions Code section 2224, subdivision (b), provides, in pertinent part, that the Medical Board "shall delegate to its executive director the authority to adopt a . . . stipulation for surrender of a license."

13. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

14. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Executive Director on behalf of the Board, except for this paragraph, which shall remain in full force and

effect. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Surrender of License, the Executive Director and/or the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Executive Director, the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving respondent. In the event that the Executive Director on behalf of the Board does not, in her discretion, approve and adopt this Stipulated Surrender of License, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Surrender of License be rejected for any reason by the Executive Director on behalf of the Board, respondent will assert no claim that the Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Surrender of License or of any matter or matters related hereto.

15. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Surrender of License and Order, including Portable Document Format (PDF) and facsimile signatures thereto, shall have the same force and effect as the originals.

16. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. No. G 68279 issued to Respondent William Arthur Landes, M.D., is surrendered and accepted by the Medical Board of California.

1. The surrender of Respondent's Physician's and Surgeon's Certificate No. G 68279 shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Medical Board of California.

2. Respondent shall lose all rights and privileges as a physician and surgeon in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificates on or before the effective date of the Decision and Order.

4. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Amended Accusation, No. 800-2014-009768 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney, Thomas J. Doyle or Chad Couchot. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No., and Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

William Landes, by Jacob Landes, power of attorney / guardian ad litem

DATED: 3/25/19

WILLIAM ARTHUR LANDES, M.D.
Respondent

I have read and fully discussed with Respondent William Arthur Landes, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: 3/26/19

CHAD C. ~~CHOUCHOT~~ Couchot
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted

//

for consideration by the Medical Board of California of the Department of Consumer Affairs.

Dated: March 26, 2019

Respectfully submitted,

XAVIER BECERRA
Attorney General of California

MARY CAIN-SIMON
Supervising Deputy Attorney General
Attorneys for Complainant

SA2017306179
21360829.docx

EXHIBIT A

XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
MARA FAUST
Deputy Attorney General
State Bar No. 111729
California Department of Justice
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 210-7544
Facsimile: (916) 327-2247
Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Amended Accusation Against: **WILLIAM ARTHUR LANDES, M.D.** 2485 Notre Dame Blvd. Ste. 230 Chico, CA 95928 Physician's and Surgeon's Certificate No. G 68279, Respondent.	Case No. 800-2014-009768 **AMENDED** **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about April 2, 1990, the Medical Board issued Physician's and Surgeon's Certificate No. G 68279 to William Arthur Landes, M.D. (Respondent). The Physician's and Surgeon's Certificate No. G 68279 was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2020, unless renewed.

///

JURISDICTION

3. This Amended Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2234 of the Code, states, in relevant part:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care."

5. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

///

///

///

///

FIRST CAUSE FOR DISCIPLINE
(Patient A.-Gross Negligence-Related to Overbilling)

6. Respondent William Arthur Landes, M.D., is subject to disciplinary action under section 2234(b), of the Code, in that he double billed for the care and treatment of patient A.[1] The circumstances are as follows:

7. In or about 2012, respondent undertook the care and treatment of patient A., a then 82-year-old man. For approximately two years, Medicare insurance paid for this patient's primary care treatment by respondent. On or about September 16, 2014, patient A. wanted to start respondent's chronic pain program for back pain and was told by respondent and/or his staff that in order to receive opiate medications/pain management services that he would have to pay respondent $300.00 in cash. For both the September 16, 2014 and the October 15, 2014, appointments, Respondent billed the Medicare Insurance program and received $300.00 in cash from patient A., for opiate prescribing/pain management services. On or about September 16, 2014, respondent prescribed 120 Norco[2] tablets 325 mg./10 mg. for lower back pain to patient A. at his initial pain management visit. On or about October 15, 2014, respondent prescribed 120 Percocet[3] tablets 325 mg./10 mg. for this follow-up pain management visit. Respondent's action of having his office bill Medicare and receive cash payments from patient A. for the same pain management services on both September 16 and October 15, 2014 constitutes an extreme departure from the standard of care in violation of Business and Professions Code section 2234, subdivision (b).

SECOND CAUSE FOR DISCIPLINE
(Patient A.-Repeated Negligent Acts)

8. Respondent William Arthur Landes, M.D., is subject to disciplinary action under section 2234(c), of the Code, in that he failed to evaluate the patient's mental capacity and he

---

[1] Patient names will be turned over in discovery.

[2] Norco, a brand name for Hydrocodone with acetaminophen, is an opioid analgesic. Prior to Oct. 6, 2014, Norco was a Schedule III controlled substance pursuant to Code of Federal Regulations (CFR), Title 21, section 1308.13(e). Thereafter, Norco was re-classified as a Schedule II controlled substance pursuant to CFR, Title 21, section 1308.12 and California Health and Safety Code section 11055(b) and a dangerous drug pursuant to California Business and Professions Code section 4022.

[3] Percocet, a brand name for Oxycodone with acetaminophen is a Schedule II controlled substance pursuant to CFR, Title 21 section 1308.12 and Health and Safety Code section 11055(b) and a dangerous drug pursuant to Business and Professions Code section 4022.

failed to evaluate the underlying causes of multiple falls in patient A. The circumstances are as follows:

9. In or about the fall of 2012 through the end of 2014, respondent noticed increasing dementia in patient A., yet never performed a mini-mental status examination or similar test to assess the patient's mental competency before obtaining informed consent from the patient to prescribe opiates, zolpidem tartrate[4], frequent corticosteroid injections, and an antidepressant. On or about July 7, 2014, patient A. had a brain CT scan that showed "extensive areas of white matter loss." Patient A. managed his medications at home, but respondent felt that the patient's wife helped manage the patient's medication for him, given his dementia, yet respondent never documented whether the wife accompanied patient A. to any of his office visits, nor discussed with the wife her management of the patient's medication. Respondent's failure to document and/or evaluate the patient's mental competency, to document and/or evaluate the patient's ability to give informed consent, and/or to document or evaluate the degree of his wife's involvement in medication management constitutes a simple departure from the standard of care.

10. On or about June 27, 2013, respondent saw patient A., after he fell and hit his head. On or about July 8, 2013, patient A. complained about two months of dizziness that respondent assessed as hypotension, dementia, afib with a pacemaker and arthritis. Respondent's plan was to "continue with current medications" including Norco and Fentanyl[5]. Patient A. had multiple falls in 2014 while suffering from hypotension, confusion and memory loss. In addition, this patient was taking opiates, zolpidem (Ambien), and paroxetine (Paxil). On or about June 27, 2014, respondent saw the patient for a follow-up visit after the patient was hospitalized for passing out a few times and for bouts of confusion. A CT brain scan was done on July 7, 2014. Respondent's plan for patient A. on July 17, 2014 was to "continue current medication" including opiates such as Norco. Respondent failed to fully assess and document the patient falls. In addition,

---

[4] Zolpidem Tartrate, the chemical name for Ambien, is a sedative hypnotic, used to treat insomnia, and is a Schedule IV controlled substance pursuant to CFR, Title 21, section 1308.14(c) and Health and Safety Code section 11057. Zolpidem Tartrate is also a dangerous drug pursuant to Business and Professions Code section 4022.

[5] Fentanyl, a generic name for the drug Duragesic, is a potent synthetic opioid analgesic, and is a Schedule II controlled substance pursuant to CFR, Title 21, section 1308.12 and Health and Safety Code section 11055(c). Fentanyl is also a dangerous drug pursuant to Business and Professions Code section 4022.

Respondent failed to evaluate the patient properly by not taking a postural blood pressure and pulse, by not performing a cardiac, and a muscle/nerve exam, and by not taking and documenting the patient's level of cognition. These failures to fully evaluate his patient constitutes a simple departure from the standard of care.

11. Complainant re-alleges paragraphs 9-10 above and the combined simple departures from the standard of care referenced in these paragraphs above collectively constitute repeated negligent acts in violation of Business and Professions Code section 2234, subdivision (c).

THIRD CAUSE FOR DISCIPLINE
(Patient B. – Gross Negligence-Related to Overbilling)

12. Respondent William Arthur Landes, M.D. is subject to disciplinary action under section 2234(b), of the Code, in that he double billed for the care and treatment of patient B. The circumstances are as follows:

13. In or about 2012, Respondent undertook the care and treatment of patient B., a then 81-year-old woman. For approximately two years, Medicare insurance paid for this patient's primary care treatment by respondent. In or about September 26 2014, patient B. needed pain medication for her arthritis, polymyalgia, and low back pain. This patient started Respondent's chronic pain program on this same date and was told by respondent and/or his staff that in order to receive opiate medications/pain management services that she would have to pay respondent $300.00 in cash. The patient asked if she could pay by check and was told that she had to pay in cash. For the April 28, 2015, March 2, 2016 and May 5, 2016 appointments, Respondent billed the Medicare Insurance program and received $300.00 in cash from patient B., for opiate prescribing/pain management services. For the April 28, 2015 patient visit, respondent prescribed 120 Norco tablets 325 mg/10 mg. For the March 2, 2016 and May 5, 2016 appointments, respondent prescribed 120 Percocet 325 mg./10 mg. tablets. Respondent's action of having his office bill Medicare and receive cash payments from patient B. for the same pain management services on April 28, 2015, March 2, 2016, and May 5, 2016 constitutes an extreme departure from the standard of care in violation of Business and Professions Code section 2234, subdivision (b).

FOURTH CAUSE FOR DISCIPLINE
(Patient A.-Inadequate or Inaccurate Medical Records)

14. Complainant re-alleges paragraphs 9-10 above and incorporates them by reference herein as though fully set forth.

15. Respondent William Arthur Landes, M.D., is subject to disciplinary action under section 2266, of the Code, in that he kept inadequate or inaccurate records of the medical evaluation and treatments of patient A. The circumstances are as follows:

16. Respondent's failure to document the patient's mental competency, to document the patient's ability to give informed consent, and to document the degree of patient's wife's involvement in medication management constitutes inadequate or inaccurate medical record keeping. Respondent also failed to document postural blood pressure and pulse, cardiac exam, and evaluations of muscle/nerve function and cognition related to the patient's multiple falls. These documentation failures constitute inadequate or inaccurate medical record keeping in violation of Business and Professions Code section 2266.

FIFTH CAUSE FOR DISCIPLINE
(Patient C.-Gross Negligence-Related to Excessive Prescribing)

17. Respondent William Arthur Landes, M.D., is subject to disciplinary action under section 2234(b), of the Code, in that he excessively prescribed anxiolytic medication (e.g. Xanax) to patient C. The circumstances are as follows:

18. On or about January 22, 2013, Respondent undertook the care and treatment of patient C., a 23-year-old male. Respondent first saw this patient for anxiety and performed an extremely limited history and physical examination. Respondent did not ask for details about patient C.'s medication treatment from other providers. Respondent wrote that "any outside records were reviewed" yet no outside records were provided. Respondent prescribed Xanax[6] 1 mg 1 BID #60 for anxiety despite patient C.'s mother's claim that her son never suffered from anxiety. On the February 21, 2013 and the March 19, 2013 follow-up office visits, the same

[6] Xanax, a brand name for alprazolam, is a Schedule IV controlled substance pursuant to CFR, Title 21, section 1308.14 and a dangerous drug pursuant to Business and Professions Code section 4022.

amount of Xanax was refilled by Respondent for patient C. Shortly after the March 19, 2013 visit, Respondent increased the patient's Xanax prescription to 2mg #60.

19. Patient C. next saw Respondent on April 3, 2013, for re-evaluation of his anxiety. The patient reported to Respondent that he was taking 4 mgs., a day and not the 2 mg. per day that was prescribed and therefore needed an increase in dosage. A physical examination was performed by Respondent and Respondent documented the exam in a description that was virtually the same as the exam on the first visit. His plan for patient C. was to increase the Xanax from 1 mg. to 2 mg. BID. On April 29, 2013 patient C. refilled the Xanax 2 mg BID #60.

20. In April 2013, Patient C. was arrested for driving under the influence of drugs. Patient C's mother, contacted Respondent's office on May 1, 2013, by telephone, and informed staff, that her son was "abusing" the Xanax which had led to her son's arrest for DUI. Patient C's mother asked Respondent's staff person to make a note in her son's medical chart about his Xanax abuse. This phone message was electronically signed by respondent and entered in patient C.'s chart on May 2, 2013. Patient C. had told his mother in early 2013 that Respondent had a reputation for handing out Oxycontin and other prescriptions to college students and this information came from patient's C.'s roommate who was an Oxycontin addict.

21. In May 2013, patient C.'s mother visited her son in Chico, California. The patient's mother found her son passed out in his room. When patient C's mother asked him what medication he was taking, he told her that he was taking 3-4 Xanax a day.

22. On May 28, 2013, Respondent again saw Patient C. for re-evaluation of his anxiety. The patient reported that his Xanax prescription had been stolen and he needed another refill. Respondent performed a physical examination, describing it in the medical record in the same words as the first physical exam. Respondent refilled that Xanax prescription for 2 mgs., #60. Respondent wrote in the record that the patient's story about the stolen medication could "sometimes [be] an indication of a problem, such as drug abuse", but the "we will give him the benefit of the doubt once".

23. On June 25, 2013, patient C. received from Respondent a refill of Xanax 2 mg., #60 and a new prescription of Oxycontin for back pain. In June 2013, patient C's mother again called

Respondent's office, this time to report not only her son's prescription abuse of Xanax but also to report the fact that he was smoking Oxycontin.

24. Respondent continued to refill Xanax 2 mg., #60 for patient C. on July 23, 2013, August 23, 2013, August 27, 2013 and September 26, 2013. Sometime in August 2013, patient C's mother moved her son home to San Jose, California and within approximately a month or so he sobered up and had stopped taking Xanax.

25. In or about October 2014, patient C. moved back to Chico, California. On October 8, 2014, Respondent prescribed patient C. Xanax 2 mg., #60. Respondent also had patient C. enroll in his pain program, where the patient had to pay $300.00 cash for each pain medication, rather than be covered by insurance. As part of this pain program, prescriptions could be sent to the pharmacy or pharmacies of the patient's choice. Respondent noted in patient C.'s chart that there had been an issue of this patient refilling Xanax with another doctor, but as the patient did not realize this action was wrong it should not be a problem. Patient C received Xanax from another physician on October 6, 2014. Respondent had patient C. sign a pain contract on October 8, 2014.

26. On January 15, 2015, Respondent prescribed to patient C. both Xanax 2 mg. #60 for anxiety and Oxycodone 10 Mg. #90 for back pain. Patient C. filled these two prescriptions at two separate pharmacies on the same day. Respondent had patient C. perform a drug test and the results showed no opiates in the patient's system. Patient C. claimed he had run out of Oxycodone medication a few days prior. When patient C. was returning home from this same office visit with respondent, he had a minor motor vehicle collision, by side-swiping a guard rail. When the police notified patient C's father of this accident, patient C. was asked to move out of his parent's home. Thereafter patient C. began to live "on the streets of San Jose".

27. Patient C. had a follow-up pain management visit with Respondent on February 20, 2015, for treatment of his back pain. Patient C. requested from Respondent that he prescribe him a stronger dose of Oxycodone[7]. Respondent increased the prescription from 10 mgs. to 30 mgs.

[7] Oxycodone with acetaminophen is generic for Percocet and is a Schedule II controlled substance pursuant to CFR, Title 21 section 1308.12 and a dangerous drug pursuant to Business and professions Code section 4022.

#90. A drug test from February 20, 2015 showed no opiates in patient C.'s system and the patient again claimed to have run out of medication a few days prior. At the physician interview of June 27, 2017, Respondent claimed that he never suspected patient C. of diverting drugs. Respondent also claimed at this same interview that he was not aware that the patient had a DUI arrest while the patient was under his care.

28. Respondent's action of prescribing the anxiolytic medication, Xanax, to patient C. constitutes multiple extreme departures from the standard of care in violation of Business and Professions Code section 2234, subdivision (b) as follows: 1) Respondent failed to conduct an adequate history and physical at the initial office visit with patient C.; 2) He failed to request patient C.'s prior medical records to verify whether the patient suffered from anxiety and had previously taken Xanax; 3) He failed to develop an adequate treatment plan with objectives such as the level of anxiety and/or sleep quality for patient C.; 4) He failed to obtain true informed consent, as there was no documented discussion of alternatives to Xanax such as counseling or stress management; 5) He failed to adequately review patient C.'s course of treatment as there were many red flags, (stolen medications, phone calls from mom about medication abuse, DUI arrest, and patient doctor shopping), that Respondent failed to follow-up on.

SIXTH CAUSE FOR DISCIPLINE
(Patient C. -Repeated Negligent Acts)

29. Complainant re-alleges paragraphs 18-27 above and incorporates them by reference herein as though fully set forth.

30. Respondent William Arthur Landes, M.D., is subject to disciplinary action under section 2234 (c), in that Respondent's failure to ask for a psychiatric consult or a psychologist for non—pharmacologic treatment of patient C., given that the dosage of Xanax that respondent prescribed was high, and that the patient's mother reported that he son did not suffer from anxiety, constituted a negligent act; Respondent's action of prescribing excessive amounts of opiates, with escalating dosages, despite red flags regarding the patient's Xanax abuse also constitutes a negligent act. These two negligent acts collectively constitute repeated negligent acts in violation of Business and Professions Code section 2234, subdivision (c).

SEVENTH CAUSE FOR DISCIPLINE
(Patient D.-Gross Negligence-Related to Excessive/Unnecessary Prescribing)

31. Respondent William Arthur Landes, M.D., is subject to disciplinary action under section 2234(b), of the Code, in that he excessively prescribed to patient D. The circumstances are as follows:

32. Respondent undertook the care and treatment of patient D., a simulated 56-year-old female patient, who was an undercover investigator for the Medical Board, on March 9, 2016. Patient D. requested that she be allowed to pay cash for the appointment. Patient D. complained to respondent that she suffered from lower back and neck pain and that she had been taking Norco, Soma and Xanax by prescription from another doctor.

33. Respondent performed no physical examination as evidenced by the undercover videotape recording, yet Respondent erroneously noted in Patient D.'s medical records that he performed a detailed physical examination of the cervical and lumbar spine. Respondent prescribed Norco 10 mg., #90 and Xanax 1 mg., #60. Patient D. paid $600.00 in cash for the two prescriptions.

34. Respondent next treated patient D. on April 21, 2016. No physical examination was performed nor did Respondent order any prior medical records. Despite no evidence of any physical examination being recorded on the videotape recording, Respondent stated that he did a detailed physical examination of the spine in patient D.'s medical chart. At this visit, a drug screen was done on patient D., with the result that the patient was negative for opiates. Respondent prescribed Norco 10 mg., #90 and Xanax 1 mg., #6 to patient D. The patient paid $300.00 cash.

35. Respondent's action of prescribing unnecessary controlled substances constitutes multiple extreme departures from the standard of care in violation of Business and Professions Code section 2234, subdivision (b) as follows: 1) Respondent failed to conduct a physical exam of patient D. on each visit, despite Respondent documenting that he performed such an exam; 2) Respondent failed to request patient D.'s prior medical records to verify if in fact another physician had previously prescribed Norco and Xanax for the patient's neck and back pain; 3)

Respondent failed to develop a treatment plan other than prescribing medication patient D. did not need; 4) Respondent failed to get informed consent from patient D., despite Respondent claiming in the medical record that he had a risk to benefit discussion on opioids with the patient, as no such videotaped discussion occurred.

EIGHTH CAUSE FOR DISCIPLINE
(Patient E.-Gross Negligence-Related to Excessive/Unnecessary Prescribing)

36. Respondent William Arthur Landes, M.D., is subject to disciplinary action under section 2234(b), of the Code, in that he excessively prescribed to patient E. The circumstances are as follows:

37. Respondent undertook the care and treatment of patient E., a simulated 62-year-old male patient, who was an undercover investigator for the Medical Board, on April 21, 2016. Patient E. requested that Respondent prescribe him Norco and Soma, for muscle spasm and pain when he is doing heavy lifting. Respondent explained that if patient E. wanted more than 30 Norco per year that he would only prescribe them through the chronic pain program and x-rays would be required. Patient D., patient E.'s simulated wife, suggested that Respondent give patient E. Xanax and Soma. Thereafter, without any evidence, Respondent stated that patient E. had a history of anxiety that Xanax could work well for. No prior medical records were requested by Respondent.

38. Respondent performed no physical examination as evidenced by the videotape recording, yet Respondent documented in the chart that he performed a lumbar spine exam that caused the patient discomfort. Respondent's assessment of his visit with patient E. was that he suffered from back spasm and anxiety. Respondent prescribed Soma 350 mg., #30 and Xanax 5 mg., #30 to patient E.

39. Respondent's action of prescribing unnecessary Xanax constitutes an extreme departure from the standard of care in violation of Business and Professions Code section 2234, subdivision (b), in that Respondent failed to conduct a physical exam of patient E., despite Respondent documenting that he performed such an exam. He failed to obtain a history about

///

patient E.'s Xanax use. He received no representation from the patient about his Xanax use and yet Respondent documented that the patient used Xanax for anxiety.

NINTH CAUSE FOR DISCIPLINE
(Patient E. –General Unprofessional Conduct)

40. Complainant re-alleges paragraphs 37-38 above and incorporates them by reference herein as though fully set forth.

41. Respondent William Arthur Landes, M.D., is subject to disciplinary action under section 2234, in that Respondent's action of falsely documenting Patient E.'s use of Xanax for anxiety and respondent's documenting that he performed a physical examination on patient E., when he did not do so, each constitute acts of unprofessional conduct.

TENTH CAUSE FOR DISCIPLINE
(Patient F.-Gross Negligence-Related to Excessive/Unnecessary Prescribing)

42. Respondent William Arthur Landes, M.D., is subject to disciplinary action under section 2234(b), of the Code, in that he excessively prescribed to patient F. The circumstances are as follows:

43. In or about December 2012, Respondent undertook the care and treatment of patient F., a then 60-year-old male, suffering from neck and lower back pain. X-rays of this patient showed degenerative changes in his spine. Respondent prescribed to patient F. for pain, Norco 10 mg., #60, monthly, from December 12, 2012 through August 2, 2014. Thereafter, Respondent increased the Norco 10 mg., to #90 per month, from August 30, 2014 through May 13, 2015. When patient F. complained that he needed stronger pain medication, on June 18, 2015, Respondent changed patient F.'s Norco prescription to Oxycodone 30 mg. #90, per month, through November 10, 2015. On December 8, 2015, when patient F. mentioned that he had increased his use of Oxycodone, from three to four a day, Respondent increased the monthly prescription to #120 Oxycodone 30 mg. from December 8, 2015 through July 30, 2016. In March 2016, respondent allowed patient F. to refill a prescription for 120 Oxycodone two times within a one-week period.

///

44. Respondent prescribed patient F. Xanax 2 mg., #60, monthly, for anxiety from December 11, 2012 through June 17, 2016. Respondent added a prescription for Soma 350 mg., #120, every other month for patient F. from August 30, 2014 through January 13, 2015, and then monthly from January 13, 2015 through July 30, 2016.

45. On two occasions, patient F. reported to Respondent that his medications had been stolen, once on November 18, 2013 and once on March 8, 2016. Respondent stated, at his subject interview of June 22, 2017, that on both reported occasions where the patient reported the theft, that he gave the patient the benefit of the doubt regarding any possible drug abuse or diversion. On August 30, 2014, patient F. signed a pain management contract. The patient began having urine test screens for opiates from October 3, 2014 through July 30, 2016. Out of the twenty-one drug tests, on ten results, patient F. tested negative for opiates. According to Respondent, this patient frequently ran out of his medication early and Respondent assumed that was the reason for the negative tests. Respondent also prescribed opiates to two other patients, who were patient F.'s relatives, and these other patients also had negative drug screens for opiates. In those cases, as well, Respondent assumed that the patients had run out of their medications rather than suspecting any possible drug abuse or diversion.

46. Respondent 's action of excessively prescribing Xanax and opioids to patient F. constitutes two extreme departures from the standard of care in violation of Business and Professions Code section 2234, subdivision (b) as follows: 1) With respect to Respondent prescribing Xanax, he failed to obtain a periodic history relating to updates about anxiety; he failed to document physical examinations relating to anxiety; he failed to periodically review the course of treatment for anxiety; he prescribed large amounts of Xanax without a treatment plan that measured the levels of anxiety or the quality of sleep; Respondent authorized weekly rather than monthly refills without justification; and the Respondent did not suspect abuse or diversion when patient F. had two alleged thefts of his medication; 2) With respect to the opiates, (Norco and Oxycodone), Respondent inappropriately increased the dosage of the medication and substituted stronger medication over time, without a referral to a pain specialist; allowed weekly rather than monthly refills; failed to question the two incidents of alleged stolen medication from

patient F. as possible abuse or diversion; he failed to question the patients negative urine tests for opiates; and he failed to formulate a long term treatment plan for the patient's pain.

ELEVENTH CAUSE FOR DISCIPLINE
(Patients D., E. and F. - Repeated Negligent Acts)

47. Complainant re-alleges paragraphs 32-34, 37-38 and 43-45 above and incorporates them by reference herein as though fully set forth.

48. Respondent William Arthur Landes, M.D., is subject to disciplinary action under section 2234, subdivision (c), in that; Respondent failed to act on an inconsistent drug screen from patient D. on April 21, 2016; Respondent failed to seek prior medical records on patient E. before prescribing Soma for alleged episodic back pain and muscle spasms; and Respondent failed to document the reason for prescribing Soma to patient F. collectively constitutes repeated negligent acts.

TWELFTH CAUSE FOR DISCIPLINE
(Patient G.-Gross Negligence-Related to Excessive/Unnecessary Prescribing)

49. Respondent William Arthur Landes, M.D., is subject to disciplinary action under section 2234(b), of the Code, in that he excessively prescribed to patient G. The circumstances are as follows:

50. Patient G. was Respondent's office manager from 2009 through at least 2016. Respondent undertook the care and treatment of patient G in October 2012, when this patient was a 33-year-old woman suffering from pain and anxiety. Respondent prescribed to patient G., Ativan[8] 1 mg., #120, a month, for anxiety from August 13, 2013 through February 15, 2016. In addition, Respondent prescribed #240 Ativan 1 mg. to patient G. on both March 14, 2016 and June 25, 2016. Respondent prescribed Norco 10 mg., #120, to patient G. for pain, from October 21, 2013 through August 25, 2014 on approximately a monthly basis. In addition, Respondent prescribed Norco 10 mg., #120 to patient G. on April 1, 2016, May 19, 2016, and June 25, 2016. Respondent documented that patient G. suffered from chest and back pain on September 26, 2013, and that this patient suffered a fall with multiple contusions on December 13, 2013. On

[8] Ativan, a brand name for lorazepam is a benzodiazepine which is a Schedule IV controlled substance pursuant to CFR Title 21 section 1308.14(c), and a dangerous drug pursuant to Business and Professions Code section 4022.

March 14, 2016, respondent documented in patient G.'s chart that she was suffering from ongoing low back and hip pain.

51. Respondent 's action of excessively prescribing Ativan and Norco to patient G. constitutes two extreme departures from the standard of care in violation of Business and Professions Code section 2234, subdivision (b) as follows: 1) With respect to Respondent prescribing Ativan for anxiety, he failed to obtain a periodic history relating to updates about anxiety; he failed to review the patient's CURES report; the CURES reports did not match the medical records regarding respondent's prescribing; he failed to periodically review the course of treatment for anxiety, he prescribed large amount of Ativan without a treatment plan that measured the levels of anxiety or the quality of sleep; 2) With respect to Respondent prescribing Norco for pain, he failed to periodically perform and document an adequate history and physical; he failed to formulate a long term treatment plan with objectives to treat the patient's pain; he failed to periodically review the course of treatment; he failed to order drug screens; he failed to review CURES reports; the CURES reports did not match the medical records regarding Respondent's prescribing; he failed to enroll the patient in a chronic pain program or have the patient sign a pain contract.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. G 68279, issued to William Arthur Landes, M.D.;

2. Revoking, suspending or denying approval of William Arthur Landes, M.D.'s authority to supervise physician assistants and advanced practice nurses;

///

///

///

///

///

3. Ordering William Arthur Landes, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: January 23, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California,
Complainant

SA2017306179
33207516.docx